Subsidies. The policy steps described above may not be enough to help lower the cost of coverage and enable working families (who do not have access to employer-sponsored coverage) to enroll in private insurance plans. The District may need to use subsidies to make insurance coverage affordable. One version of such subsidies makes use of tax credits. These credits could be made available to employers and/or employees. Credits for employers could have the additional value of helping to attract or retain businesses in the District. A daunting challenge facing this strategy is the difficult tradeoff between fairness and cost. If the credits are provided only to companies newly offering coverage, cost can be kept manageable, but firms that have already been funding health insurance would understandably feel that they were unfairly treated. In contrast, if credits were offered to all companies offering coverage, the cost would balloon and public sector dollars would not be well targeted to the currently uninsured. One way to address this problem would be to target the credits to firms with relatively low average wages; this may raise some administrative problems but could be worth exploring.

Tax credits for workers would cover a portion of their premium contributions and out-of-pocket health costs. Workers with family coverage typically pay about one-fourth of the premium for employer-sponsored coverage and the employer pays the remainder.[15] This worker's portion is now approaching $2,000 a year in many parts of the country. In addition, copayments and deductibles are rising, and coinsurance is being used more widely. These increases add substantial out-of-pocket costs to premium contributions. With support from the foundation, the District could assess the experience of states such as Massachusetts and Rhode Island that are trying to develop premium assistance programs for lower-income employees. Experience to date indicates that these types of initiatives must be carefully designed and heavily "marketed."[16] To avoid low take-up rates, subsidies must cover a good share of the premium—but this, of course, raises the public cost. A variety of media and personal outreach must be combined to get business and workers to participate. Subsidies will also be more effective if firms and workers have a way to use them to obtain affordable group coverage such as purchasing cooperatives (discussed above).

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[15] The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits, 2001 Annual Survey*, Exhibit 7.2.

[16] Silow-Carroll, Sharon, *Employer Tax Credits to Expand Health Coverage: Lessons Learned.* Economic and Social Research Institute. Prepared for The Commonwealth Fund, February 2000.

Possible fundable activities:

- For any of the private sector coverage options listed above, the foundation would not fund the coverage directly, but rather *provide funding for the District to investigate and assess* some of these options in more detail. The District may want to devote staff time or contract with consultants who have experience working in the District to conduct policy work outlining the pros and cons of the various strategies; look in detail at what some other states and localities have done that might be applicable in the District; and develop cost-estimates for the various strategies that seem most promising. This is an immediate need in the District, as public coverage expansions may not be the most effective, affordable, or feasible way of ensuring coverage for all of the District's remaining uninsured.

- If the District were to decide to pursue one or more of the strategies listed (for example, develop a high-risk pool for "uninsurable" individuals along with a tax credit program), more detailed policy work and cost analysis would be needed to develop a specific implementation plan. To help the city meet this need, the foundation could *fund a planning grant.* And, even further down the line, if something like a tax credit or premium subsidy were passed, studies indicate that a significant amount of marketing would be needed to encourage a healthy "take-up" rate. To support this effort, the foundation could *provide start-up funds for activities* such as marketing, or for administrative support to get the program up and running.

II. STRENGTHENING THE SAFETY NET

For the foreseeable future, even with the development of the Alliance, the District will be faced with a substantial number of uninsured people. To address their needs, as well as the needs of people enrolled in Medicaid who still have trouble gaining access to timely services (because of economic, transportation, cultural, language, and/or other barriers), it is important to streamline and rationalize the delivery system to improve health outcomes.

Health system restructuring. One important step is to reallocate funds within the health care system to address unmet needs. Through the development of the Alliance, the District has taken some steps in the direction of the type of health care system restructuring that has been undertaken successfully in other urban areas such as Los Angeles. There, the Department of Health Services transformed its hospital-based public health care system into a provider network focused on ambulatory and primary care. Total budgeted L.A. County hospital beds were reduced by 28 percent

over five years. The County contracts with the community-based organizations, medical groups, and hospitals that can best serve the ambulatory care needs of particular populations or geographic areas. The number of ambulatory care sites more than tripled over five years, and all of the more than 100 new sites are privately managed.

Georgia has taken a somewhat different approach to solving the same type of imbalance in resource allocation. The state added a requirement to its Disproportionate Share Hospital (DSH) program that 15 percent of the DSH funds received by hospitals in the state be used to support primary care services.[17] Following this lead, the District could require recipients of DSH funds to apply some portion of the funds to services for uncompensated care patients referred from the primary care system to the DSH hospital. This would better utilize the current over-supply of hospital beds and better align the size of DSH payments with the actual uncompensated care burden.

Capital improvements. Last year, $5 million was allocated for improvements at Greater Southeast Hospital, and was spent. Another $1 million went to D.C. General for repairs. An additional $5 million was allocated to community health centers, and most of this money is not yet spent. This is a microcosm of the larger problem. The health centers need a business plan for modernization, staffing needs, ancillary services, and the development of linkages to downstream levels of care. The District may want to work with an organization such as the Local Initiatives Support Corporation (LISC), a national nonprofit intermediary that channels private sector financial and technical resources to community development corporations (CDCs). LISC's mission is to assist CDCs in transforming distressed neighborhoods into healthy communities. It serves as a broker, lender, advocate, and technical assistance provider.[18]

The District may also want to begin earmarking a portion of tobacco settlement funds for meeting some of the needs of its primary health care system instead of devoting the money to deficit reduction.

Technical assistance underwritten by the foundation could help the District develop these types of funding strategies, as well as a good plan for prioritizing outlays to get the best return. Some funds could be used for MIS improvement; some for staff; some for plant and equipment improvements.

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[17] For more information, see the section on the Indigent Care Trust Fund on the Georgia Department of Community Health website, www.communityhealth.state.ga.us.

[18] Government of the District of Columbia. *Strategies for Change.* Health Care System Development Commission. Final Report. December 2000.

Another important target would be the development and implementation of quality of care measures and targets for improvements. This could involve a subset of HEDIS indicators for health plans, risk-adjusted mortality rates for hospitals, volume/outcome relationships, or other measures.

Direct Service Outreach. The development of a better infrastructure in the primary health care system can be effectively complemented through grassroots community outreach. For example, a Consumer Health Access Team (CHAT) has been formed by the Department of Health and will work with community organizations like the East Capitol Center for Change. These are four-person teams made up of consumers from underserved areas in the city. These people, who have experience using the public health system in the District, provide advice and counsel to people in emergency rooms, local businesses, churches, laundromats, and buses. They are developing a Web-based system to track their contacts. In addition, they will work with the Department of Health to provide feedback on Alliance services and help the Department of Health monitor and manage the Alliance contract.

A more fully developed program of community health workers has been implemented in North Manhattan, which is also one of the 13 W.K. Kellogg Foundation's Community Voices sites. Community members are trained about eligibility for public programs. They learn outreach strategies, develop communications skills, and evaluate what is working in signing up parents and their children for Medicaid and S-CHIP. Workers go door-to-door to identify people who are eligible for public programs, and they distribute flyers and conduct surveys. Ultimately, some of these community members become paid staff. The workers, in effect, become "extenders" of the traditional medical model and help connect residents with services.

Other possible targets of opportunity for outreach involve door-to-door campaigns to enroll eligible children and parents in S-CHIP and Medicaid, and neighborhood health fairs at grocery stores, recreation centers, etc. to promote the use of preventive tests and access to information on health improvement.

Possible fundable activities:

- The foundation could *fund a study* to look at sites like Los Angeles or Georgia and see if either of those initiatives might be a feasible way to conduct health system restructuring in the District.

- The foundation, working with an organization such as the Non-Profit Clinic Consortium, could *provide support for developing a citywide business plan* for making much-needed capital improvements to the clinics.

- If specific capital needs arose for which there did not appear to be available funding, the foundation could *directly fund some capital improvements*, such as improving waiting rooms (painting, buy toys, etc.) or funding a dental chair.

- The foundation might *fund some additional staff time* to allow for longer clinic hours, or increase the services offered at a clinic (e.g., hire a dental hygienist, etc.).

- The foundation could *provide support to convene the clinics to develop a plan* around how tobacco settlement funds could be used to support the development of health care infrastructure in the city (there has already been some work done in this area).

- The foundation could *underwrite an expansion of direct service outreach* using community health workers (CHWs), now being pilot-tested on a small-scale under a grant from the W.K. Kellogg Foundation.

- The foundation could *fund consultants to provide technical assistance* to clinics to help them implement MIS improvements and develop IT plans, undertake strategic planning, conduct fund-raising activities, etc.

III. Health Initiatives and Disease Management Strategies

Coupled with improvements needed in the safety net delivery system and direct service outreach to enroll eligible people in health coverage and improve access to care, a new foundation could also assist the District in planning new initiatives in disease management and medication compliance. As noted earlier, District residents have an unusually high incidence of various chronic medical conditions such as asthma, diabetes, and cardiovascular diseases.

The city already has a program targeted to asthma management. This effort could be augmented by further support from the foundation community to help the city meet the goals developed under *Healthy People 2010*. For example, national targets require reductions in both the death rate from